MISSISSIPPI RURAL
HEALTH CARE PLAN

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Approved: Mississippi State Board of Health, January 13, 1999
Health Care Financing Administration, March 10, 1999

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INTRODUCTION AND PURPOSE OF PLAN

Section 4201 of the Balanced Budget Act of 1997 (Public Law 105-33) sets forth rules for the Medicare Rural Hospital Flexibility Program. Any state may establish a rural hospital flexibility program if it submits assurances that the state has developed **S** or is in the process of developing **S** a rural health care plan that provides for the creation of one or more rural health networks, promotes regionalization of rural health services in the state, and improves access and other services for rural residents.

This plan is submitted on behalf of the State of Mississippi to develop a system of rural health care. It has been developed by the Mississippi State Department of Health, Division of Health Planning and Resource Development, which contains the Health Planning Branch, the Certificate of Need Branch, and the Office of Rural Health Branch, in consultation with the Mississippi Hospital Association, the Mississippi Association of Supervisors, and in collaboration with rural hospitals in the state.

TABLE OF CONTENTS

I. State Profile

II. The Organization and Support of Rural Health Systems in Mississippi

III. Mississippi Rural Hospital Flexibility Program

Appendices

I. STATE PROFILE

A. Description of State

Mississippi is bounded on the north by Tennessee; on the east by Alabama; on the west by Arkansas and Louisiana; and on the south by the Gulf of Mexico. Mississippi contains 47,715 square miles, mostly rural farmland. In the north, the large, fertile alluvial Delta was mostly swamp until the mid 1850s, when by the sweat of men and mules, some 300 miles of levees claimed this broad region. At the Delta's eastern edge, the land suddenly changes from table-flat to the rising loess bluff hills, stretching north into Tennessee and south into Louisiana. From Mississippi's northeast hills southward, the land changes into rolling farmland, hardwood highlands, then red clay hills to fertile pasture lands, on to piney forests, eventually giving way to the man-made white sand beaches of the Gulf Coast.

B. Population Distribution and Demographics

The 1990 Census reported Mississippi's population as 2,573,216. Mississippi's population, which ranks 31st in size among all states, is dispersed throughout 82 counties and 290 incorporated cities, towns, and villages. While three-fourths of the state's citizens reside in one of these incorporated places, 52.7 percent of the population lives in areas classified as rural by the U.S. Census Bureau, making it the fourth most rural state in the nation. Less than 20 percent of Mississippians reside in one of the eight cities with a population of 25,000 or more, and only one-third live in cities of 10,000 or more residents. The state has three standard metropolitan statistical areas (SMSAs): the Gulf Coast (Hancock, Harrison, and Jackson counties), the Jackson area (Hinds, Madison, and Rankin counties), and the Hattiesburg area (Forrest and Lamar counties). DeSoto County is included in the Memphis SMSA.

C. Mississippi Economic Data

1. The 1990 Census reports 1,010,423 housing units, with an average occupancy of 2.55 persons per unit and an average family size of 3.27 persons.

2. The Mississippi Employment Security Commission reported an average citizen labor force of 1,270,400 in December 1997. Seven counties reported a double-digit unemployment rate, and 45 counties reported an unemployment rate less than five percent.

3. The 1990 Census reported Mississippi's per capita and median family income as 50th in the nation, with $9,648 per capita and $24,448 median family income compared to $14,420 and $35,225 for the United States, respectively.

4. The number of Mississippians over the age of 25 with a bachelor's degree or higher was 14.7 percent, compared to 20.3 percent for the nation.

D. Health Status of Mississippi

Statistics present an extremely negative view of the overall health in Mississippi, as has been the case historically. Compared to national health statistics, Mississippi's residents rank lowest in overall health indicators. Rural residents tend to be less healthy than urban residents. Transportation issues and ability to pay for health care affects overall health status.

1. Live Births

In 1996, Mississippi experienced 40,978 live births. A physician attended 97.9 percent of all in-hospital live births. Nurse midwife deliveries accounted for 682 live births. More than 75 percent (513) of the nurse midwife deliveries were non-white. Mississippi experienced the following statistics in 1996:

a. More than 98 percent of expectant mothers received prenatal care.

b. Approximately 99 percent of the live births occurred in the 15 to 44 years age group.

c. More than 45 percent of these births were to unmarried women who gave birth to 18,458 children.

d. The birth rate was 15.2 live births per 1,000 population.

e. Fertility rate was 65.2 live births per 1,000 women aged 15-44 years.

f. At least 9.9 percent of births were either low birth-weight or premature.

g. At least 11.4 percent of the births to teenagers were low birth-weight and 16.9 percent were premature.

h. A total of 619 (151.1 per 10,000 live births) congenital malformations were reported. Agricultural chemicals could have influenced some of these congenital malformations.

i. Mississippi experiences the highest percentages of births to teenagers in the nation, at 21.3 percent of all live births — a total of 8,745 children.

2. Mortality Statistics

Statistically, Mississippi portrays an extremely negative overall health picture compared to national statistics. Rural residents tend to have less access to health care than urban residents; transportation and the ability to pay also affect overall health status.

a. Fetal Deaths

Mississippi reported 453 fetal deaths during 1996 for the fetal death rate (fetal deaths per 1,000 live births) as follows:

i. 40.8 to mothers aged 40-45

ii. 13.5 to mothers aged 35-39 and to children less than age 15

iii. 11.2 to mothers aged 15-19

iv. The fetal death ratio for non-whites was 15.6, more than twice that for whites at 6.9.

b. Maternal Deaths

Maternal mortality refers to death resulting from complications of pregnancy, childbirth, and the purpureum within 42 days of delivery. The MSDH received reports of one such death during 1996. Some health care professionals believe that maternal deaths are under-reported.

c. Infant Deaths

Mississippi experienced 451 deaths of infants — children less than one year of age — during 1996. The total included 294 neonatal deaths (within the first 27 days) and 157 post-neonatal deaths (28 days to less than one year).

Congenital anomalies (102), disorders relating to short gestation and unspecified low birth-weight (57), sudden infant death syndrome (48), and accidents (21) constitute the four leading causes of infant deaths in both Mississippi and the United States. These resulted in more than half of all infant deaths in Mississippi during 1996.

The major factors in neonatal deaths were congenital anomalies (76), disorders relating to short gestation and unspecified low birth-weight (57), and respiratory distress syndrome (19). The major causes of post-neonatal deaths were sudden infant death syndrome (46), congenital anomalies (26), and accidents (18).

d. Infant Mortality Rate

The mortality rate for non-white infants was reported at more than twice that for white infants **S** 14.4 deaths per 1,000 live births to 7.9 for whites. This

difference is comparable to national figures. Many researchers believe that inadequate prenatal care among non-white mothers and a higher incidence of low birth-weight for non-white infants contributes to this drastic difference.

In the five-year period 1992 to 1996, 41 counties in Mississippi had infant mortality rates above the State average of 11.2 per 1000 live births. Three of the top ten counties had lower rates of live births to mothers-at-risk than did the state at large; the other seven had higher rates. Tunica County reported the highest incidence of live births to teenagers while Panola County had the highest rate of low birth-weight infants.

e. Death and Death Rates

There were 26,566 deaths reported in 1996, for a death rate of 9.9 per 1,000 population. The largest proportion of deaths occurred among whites aged 65 and older, which was 49.0 percent (13,024) of the total. Non-whites in the same age group accounted for 20.1 percent. More than 69 percent occurred in the two combined groups.

f. Leading Causes of Death and Death Rates

Ten leading causes resulted in 82.4 percent of all deaths in Mississippi during 1996, as shown below. Heart disease remains the leading cause of death in Mississippi and in the United States.

Non-whites were 3.2 times more likely to die from homicide and legal intervention than were whites. Whites were 3.3 times more likely to die from suicide and 2.7 times more likely to die from emphysema and other chronic obstructive pulmonary diseases (COPD) than were non-whites. Overall, the death rate for the ten leading causes was more than 6.2 percent higher among the white population than the non-white population (10.3 and 9.7 per 1,000, respectively).

Number of Deaths, Death Rates, Percentage of Total Deaths, and Relative Risk for the Ten Leading Causes of Death Mississippi 1996

Cause of Death	Number	Death Rate[1]	%of Total Deaths	Relative Risks[2]
All Causes	26,566	986.5	100.0	0.9
Heart Disease	9,499	352.7	35.5	0.8
Malignant Neoplasms	5,732	212.8	21.6	0.8
Cerebrovascular Diseases	1,691	62.8	6.4	0.9
Accidents	1,512	56.1	5.7	1.1
Emphysema & Other COPD	1,003	37.2	3.8	0.4
Pneumonia and Influenza	884	32.8	3.3	0.7
Diabetes Mellitus	533	19.8	2.0	1.7
Homicide/Legal Intervention	377	14.0	1.4	3.2
Nephritis, Nephritic Syndrome and Nephrosis	351	13.0	1.3	1.7
Suicide	310	11.5	1.2	0.3
All Other Causes	4,674	173.6	17.6	1.1

[1] Per 100,000 population
[2] Rate for nonwhite/rate for whites (i.e. nonwhites vs. whites)

Source: Vital Statistics Mississippi, 1996, Mississippi State Department of Health Bureau of Public Health Statistics

3. Morbidity Statistics

Morbidity reports depict the health status of a region by reflecting patterns of change in health conditions — both positive and negative. Morbidity data provide a basis for health resource planning and help determine the need for beds in facilities. In general, current morbidity data are not available. Other than hospital utilization data and selected data compiled by the Department of Health, morbidity information is not only difficult to obtain, but is usually outdated upon receipt.

Mississippi Morbidity Facts

a. Mississippi historically leads the nation in the number of new tuberculosis cases reported each year. Such cases reported in 1997 numbered 246 of which 82 percent were pulmonary tuberculosis.

b. The MSDH Cancer Registry estimates that 12,800 new cases of cancer will

be detected in 1998, with 6,000 cancer fatalities during the year.

c. Mississippi had a total of 1,341 cases of early syphilis and 9,024 cases of gonorrhea for 1997. The State also has similar problems with non-reportable sexually transmitted diseases, such as herpes and chancroid.

d. A total of 270 cases of AIDS and 520 cases of HIV were reported in 1997.

e. Twenty-four cases of meningitis, 86 cases of Hepatitis A, 166 cases of Hepatitis B, 8 cases of Hepatitis C, 442 cases of Salmonellosis, and 107 cases of Shigellosis were reported to the MSDH in 1997.

4. Occupational Injuries and Illnesses

The Mississippi Worker's Compensation Commission produces an annual report on work place injuries and illnesses using information compiled from accident report forms that employers must submit to the Commission. The report shows that work-related injuries and illnesses place significant demands on industry. Such information helps industry to focus on safe work practices and injury prevention through the implementation of safety programs.

Statistical highlights of the Commission's *1996 Annual Report of Occupational Injuries and Illnesses* (most recent available) are as follows:

a. Work-related injuries or illnesses resulting in six plus days work of absence — 17,421.

b. Strains — 6,522 claims (37.4 percent).

c. Lower back pain — 3,466 claims (19.9 percent).

d. Injuries or illness associated with lifting — for 3,122 claims (17.9 percent).

e. Major injuries or illnesses occurred on Monday more than any other day of the week with 3,379 claims (19.4 percent).

f. Fatalities — 102.

g. Insurance carriers and self-insurers paid a total of $224,340,970 in 1996; $124,650,635 for medical expenses and $99,690,335 for indemnity benefits.

h. The top five industries reporting work-related injuries and illnesses during 1996 were:

Industry	Number of Job-Related Injuries/Illnesses	Percentage of Total
Manufacturing	5,695	32.1
Services	4,166	23.9
Retail Trade	2,271	13.0
Construction	1,900	10.9
Transportation	1,432	8.2

E. Third Party Reimbursement

Medicare is a federally-administered program which covers hospital, physician, and other medical services for most persons 65 years of age and older and disabled persons entitled to Social Security cash benefits for 24 months. Medicare consists of two parts: compulsory hospitalization insurance (Part A) and voluntary supplemental medical insurance (Part B), which covers physician services and some medical services and supplies not covered by Part A.

Medicaid is another third party reimbursement program providing health care services for eligible persons. The Mississippi Division of Medicaid administers state appropriated funds and federal matching funds within the provisions of Title XIX of the Social Security Act, as amended, to provide medical assistance for needy Mississippians. Medicaid includes 11 mandatory services and nine optional services. The mandatory services are inpatient hospital; outpatient hospital; laboratory and x-ray; nursing facility services; physician services; early and periodic screening, diagnosis, and treatment (EPSDT) for patients aged 20 and under; home health; family planning; rural health clinic services; transportation/emergency ambulance services; and nurse-midwifery services. Optional services are outpatient prescription drugs, dental services, intermediate care facility services for the mentally retarded, eyeglasses after surgery, home and community based services, durable medical equipment, mental health services (comprehensive regional mental health/retardation centers), and inpatient psychiatric services for persons under age 21.

In 1997, 20.18 percent (509,303) of Mississippi's population were Medicaid recipients. Nationally in 1995, 13.4 percent of the population were Medicaid recipients. Twenty-nine percent of Medicare recipients also covered by Medicaid, compared to 12.5 percent nationally.

The Department of Defense operates the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) which provides health insurance for covered medical care provided in civilian facilities to wives and children of active military personnel, retired military personnel and their dependents, and dependents of deceased personnel (unless eligible for Part A of Medicare). The program is designed for those unable to use government medical facilities because of distance, overcrowded facilities, or the absence of appropriate treatment at a military medical center.

F. Managed Care In Mississippi

Managed care has been slow to gain support in Mississippi. Concerns about potential financial losses, loss of autonomy, and an influx of non-Mississippi-based insurers are some of the most commonly voiced reasons why providers and insurers have resisted managed care. In addition, the lack of large employers reduces the pressure for "prudent purchasing." The state government is the largest employer, and it has made efforts to promote managed care; however, employees feel that insurance rates are reasonable, so there is no incentive to select a managed care option. In addition, the casinos, which are among the state's large employers, typically operate self-funded indemnity-style plans.

The delivery of health care services through HMOs has existed in some parts of the United States since the 1930's. These organizations have proliferated throughout the country in recent years. Over the past four years, there has been scarce interest in the Mississippi HMO market. Sixteen HMOs were operating in Mississippi as of March 1998 and three other organizations had applied for a Certificate of Authority. However, commercial HMO penetration is very small. The Department of Insurance estimates that about one percent of the total state population was enrolled at the end of 1995. Industry data suggest that HMO penetration has grown to two percent presently.

The exact number of PPOs formed or operating in the state has not been determined; however, it is assumed to be between 50 and 100. It is also difficult to determine PPO penetration rates. However, PPOs are believed to be much more popular than HMOs, but without the ability to identify PPOs, calculating penetration rates is impossible.

II. THE ORGANIZATION AND SUPPORT OF RURAL HEALTH SYSTEMS IN MISSISSIPPI

A. Hospitals

Mississippi had 100 non-federal acute care hospitals in May 1998, with a total of 11,670 licensed medical-surgical beds. Local government controls 70 of these hospitals; non-profit organizations own 18 hospitals; and for-profit corporations own 12 hospitals. The State of Mississippi owns and supports University Hospital, the teaching hospital associated with the University of Mississippi Schools of Medicine, Dentistry, Nursing, and Health Related Professions. Control of 47 of the hospitals rests with local government, two with state government, 34 with non-profit organizations, and 17 with for-profit corporations.

The count excludes Whitfield Medical-Surgical Hospital, a 43-bed facility providing acute care to psychiatric patients at the Mississippi State Hospital at Whitfield, and the Medical-Dental Facility at Parchman, a 56-bed facility providing acute and psychiatric care to inmates at the Mississippi State Penitentiary. In addition, the state has three licensed long-term acute care hospitals, Specialty Hospital of Meridian (20 beds), Biloxi Specialty Hospital of Biloxi (42 beds), and the Restorative Care Hospital at Baptist, Jackson (25 beds). These hospitals provide care to patients who need less than three hours of rehabilitation per day but have an average length of stay greater than 25 days.

The federal government operates two Veterans' Administration Hospitals, located in Jackson and Biloxi, which provide health care services for eligible veterans of the military. The United States Air Force operates medical facilities at Columbus and Biloxi to serve active duty military personnel at Columbus and Keesler Air Force Bases and their dependents and retired military personnel and their dependents. The Indian Health Service operates a 35-bed hospital in Philadelphia, serving Choctaw Indians from Kemper, Noxubee, Leake, Neshoba, Newton, and Scott Counties. See Maps I and II for the distribution of hospitals by facility type (Map I) and by bed size (Map II).

Seven counties in Mississippi do not have a hospital: Amite, Benton, Carroll, Greene, Issaquena, Itawamba, and Tunica. However, these counties appear to receive sufficient inpatient services from hospitals in adjoining counties.

To see map, go to http://www.msdh.state.ms.us/rural/map1.pdf

To see map on page 11, go to http://www.msdh.state.ms.us/rural/map3.pdf

1. Demographics

The 1990 U.S. Census revealed that the health problems of Mississippians are the result of the state's social, economic, and educational conditions. The following facts indicate a brief overview of these conditions:

a. Mississippi has the lowest per capita and family income in the nation.

b. Residents aged 65 and older make up an estimated 12.3 percent of the population.

c. The state ranks first in people aged 65 and older with incomes below the poverty level.

d. Mississippi ranks first in persons aged 65 and older who are severely disabled and second in the percentage of people aged 65 and older who receive Medicaid.

e. In 1997, the Mississippi State Medicaid Program provided health coverage for 20.18 percent of the state's population, while another 19.5 percent were uninsured.

f. The number of hospital discharges for 1997 was 391,228, with an average length of stay of 5.41 days. Of these discharges, 156,611 were for persons aged 65 and older.

2. The Rural Hospital

The following section describes the types and numbers of rural health facilities in Mississippi that comprise the rural health infrastructure. Programs aimed at improving rural health services are also described in some detail to include recruitment/retention programs and supporting rural health networks.

The State of Mississippi is committed to assisting communities in determining the best course of action in planning and developing rural health systems, including plans that improve access to health services, reduce duplication of services, and networking services and facilities where appropriate, with the ultimate goal of providing a "coordinated community-based continuum of care."

3. Profile of Rural Hospitals

Currently, 81 of the 100 non-federal acute care hospitals in the state are considered rural (located outside of Metropolitan Statistical Areas). They contain 65.4 percent of the total number of licensed acute care beds **S** 7,632 rural

hospital beds **S** in 1998. Twenty-two (27.2 percent) have 100 or more beds; 24 (29.6 percent) have 50-99 beds; and 35 (43.2 percent) have fewer than 50 beds.

The pressures of a rapidly changing health care environment affect the financial viability of many rural hospitals. These hospitals face limited revenues, inadequate population bases, and regulatory constraints. A number of alternatives have emerged as administrators and hospital boards attempt to cope with the increasing distress experienced by the nation's rural hospitals, particularly the smaller ones. One possibility is to diversify a hospital's activities by adding new services to offset dwindling inpatient demand. Another alternative is forming alliances of rural hospitals to achieve better economies of scale in areas such as purchasing or acquisition of new resources, while maintaining individual autonomy. A number of rural hospitals have entered into more formal multi-hospital arrangements where the hospital is owned, leased, or managed by another larger hospital or parent corporation. This arrangement usually diminishes the autonomy of the individual hospital.

The number of multi-hospital arrangements in Mississippi has grown in the past several years. Eight such arrangements existed in the spring of 1998. The eight networks involve 26 of Mississippi's hospitals, and all but five are rural. These more formal networks range in size from two to seven hospitals. Health care management systems based in Tennessee head two of the networks. A system based in Florida heads a third network.

The federal government took several actions to help rural hospitals, such as increasing reimbursement through changes in the Medicare prospective payment system. Other actions include programs to use excess hospital beds, modify services, recruit physicians, and encourage participation in consortia with other local providers to expand, improve, or initiate new services. A number of these activities specifically target rural hospitals: the swing-bed program, the small Medicare-dependent hospitals provision, and Rural Health Outreach grants. These grants encourage hospitals to form consortia with other providers to deliver new services to unserved rural populations. Congress also changed the Rural Health Clinic Act to encourage the establishment of freestanding or hospital-based clinics using mid-level practitioners, with services reimbursed on a cost basis. Congress has increased funding for the National Health Service Corps, which could increase inpatient physician referrals to hospitals located in Health Professional Shortage Areas.

The federal government has funded several demonstration projects to explore the feasibility of converting small rural hospitals to short-stay low intensity acute or subacute inpatient care and a combination of ambulatory primary care

and/or 24-hour emergency care. The resulting new facilities would be called medical assistance facilities or rural primary care hospitals and would have established referral agreements with larger hospitals. Demonstration projects include the Medical Assistance Facility Demonstration in Montana and the Essential Access Community Hospital Program in seven pilot states.

Individual small rural hospitals will continue to experience multiple pressures in the foreseeable future, which will affect their ability to provide acute inpatient care. Mississippi needs increased collaborative efforts by health care providers, local communities, the state, and the federal government to assure that rural citizens have reasonable access to a full range of health care services. This goal may best be achieved through systems of health care in which the small rural hospital is one component, though not necessarily the inpatient component.

B. Swing-Bed Programs and Extended Care Services

Patients who are ready for discharge from the hospital often experience difficulty in finding a nursing home where they can continue recuperation. This situation causes hospital costs to be higher than necessary when nursing home transfers are delayed due to a lack of available beds. Mississippi has very few Medicare-certified nursing home beds; therefore, many patients are unable to utilize the Medicare nursing facility benefit. Moreover, the state may have to pay for nursing facility care through the Medicaid program that could otherwise be funded through Medicare. The use of swing beds could help alleviate such problems without new construction and with mostly Medicare funds.

Swing-beds provide a link between inpatient acute care and home or community-based services in a continuum of care for the elderly and others with long-term needs. If return to the community is not possible, the swing-bed hospital assists the patient and family with nursing home placement. The swing-bed concept may help alleviate the problem of low utilization in small rural hospitals and provide a new source of revenue with few additional expenses. Additionally, swing-beds allow hospitals to better utilize staff during periods of low occupancy in acute care beds.

1. Swing-Bed Utilization

Mississippi's 54 swing-bed hospitals reported 4,188 admissions to swing beds during Fiscal Year 1997, with 70,633 patient days of care and an average length of stay of 16.70 days. The number of days of care provided in swing beds was equivalent to approximately 194 nursing home beds.

The swing-bed program offers a viable alternative to placement in a nursing home for short-term convalescence. Only about 15.9 percent of the patients who were cared for in a swing-bed during 1997 were discharged to a nursing home. Many more of these patients may well have ended up in a nursing home if swing-bed services had not been available.

2. Long-Term Care

Mississippi's long-term care patients are primarily disabled elderly people, who

make up 17 percent of the 1997 population above age 65. Officials project the number of people in this age group at approximately 341,600 by 2000, with one in ten over age 85, and more than 58,000 disabled in at least one essential activity of daily living.

a. Home and Community-Based Services

When people hear the phrase "long-term care", nursing homes generally come to mind. In reality, most people receive long-term care at home or in the homes of family members. Only 7.97 percent of Mississippi's total population over age 65 lived in a nursing home during calendar year 1997. "Long-term care" simply means assistance provided to a person who has chronic conditions that reduce their ability to function independently. Many people with severe limitations in their ability to care for themselves are able to remain at home or in supportive housing because they have sufficient assistance from family, friends, or community services.

The Mississippi Division of Medicaid funds a statewide program for home and community-based services under a federally granted Medicaid waiver. The waiver program currently operates through the Division of Aging and Adult Services and the state's ten Area Agencies on Aging, with a maximum of 2,600 participants. Under this program, eligible individuals can choose to receive supportive services in their own homes rather than enter a nursing home. Services include homemaker assistance, one home-delivered meal five days each week, adult day care or institutional respite care if needed, and more home health visits than allowed under the regular Medicaid program. To participate in the waiver program, individuals must need enough assistance to qualify for admission to a nursing home and must meet eligibility requirements for S.S.I. (Supplemental Security Income). Other home and community-based programs funded through such programs as the Older America Act served 7,471 clients through in-home services, 44,185 through community services, and 18,585 through the congregate and home delivered meals programs. Of these persons served, 28,113 were rural residents.

b. Skilled Nursing and Intermediate Care Facilities

Skilled nursing homes provide another component of Mississippi's health care system. The state has 172 public or proprietary nursing homes, with a total of 15,923 beds; one nursing home operated by the Mississippi Band of Choctaw Indians, with 120 beds; two nursing homes operated by the Department of Mental Health, with a total of 679 beds; and four nursing homes operated by the Mississippi State Veteran's Affairs Board, with a total of 575 beds. The state has 10 intermediate care facilities for the mentally retarded - five proprietary and five operated by the state - with a total of 2,329 beds. (The Ellisville State

School includes four separately-licensed facilities.) The state also has four psychiatric residential treatment facilities for emotionally disturbed children and adolescents, with a total of 158 licensed beds.

In addition, 34 Mississippi hospitals provide limited nursing home care in "distinct part skilled nursing facilities". These units are located in a physically identifiable distinct part of the hospital and are certified for participation in the Medicare program as skilled nursing facilities, but cannot participate in the Medicaid program. As of May 1998, a total of 677 beds were approved under this program; 584 were in operation.

Another 51 hospitals offer care in "swing beds", which are beds approved to alternate as needed between acute care and long-term care in hospitals of fewer than 100 beds. These hospitals provided care equivalent to 194 nursing home beds in FY 1997.

c. Personal Care

Individuals who need some custodial care or assistance with the activities of daily living, but do not require skilled nursing services, may choose to live in a licensed personal care home. Mississippi has 181 such homes, with a total of 1,892 licensed beds.

Numerous retirement communities or assisted living facilities provide independent living areas for individuals who need a sheltered environment, including nutritional and social support, but who do not require institutional health care. The state's ten Area Agencies on Aging coordinate home and community-based services such as adult day care, respite care, congregate or home-delivered meals, and chore/homemaker services.

C. Community Health Centers

Community Health Centers provide access to medical care for residents who are plagued by a shortage of medical services, financial restrictions, and other social or economic barriers. The centers coordinate federal, state, and local resources to effectively deliver health care services in rural and underserved areas and provide a true health care "safety net" for the medically disadvantaged.

Mississippi has 20 Community Health Centers and 36 satellite clinics. Eighteen centers operate in rural areas, and two are located in urban areas. Two centers operate mobile units. During calendar year 1997, these centers provided services to more than 203,000 Mississippi citizens and recorded more than 700,000 patient visits.

D. Rural Health Clinics

Rural health clinics may be freestanding facilities owned by physicians or

provider-based clinics established by hospitals, nursing homes, or home health agencies. A total of 164 certified Rural Health Clinics operated in Mississippi as of April 1998. Utilization data for rural health clinics is not reportable.

E. Behavioral Health

The Mississippi Department of Mental Health (MDMH) administers two state psychiatric hospitals, five residential centers for persons with mental retardation, community mental health and mental retardation services for children and adults, and a variety of alcohol and drug prevention and treatment programs. Through contracts and affiliations with the state's community mental health/mental retardation centers and other public and private agencies, the MDMH strives to ensure a continuum of community prevention, treatment, training, and support services. The Department offers a range of services to persons with mental retardation and developmental disabilities through a variety of programs, including preschool programs, alternative living arrangements, work activity centers, and long-term residential care. In addition to the MDMH, 15 regional community mental health/mental retardation centers and their satellite facilities, as well as other nonprofit programs, provide a network of services throughout the state.

Mississippi has 18 hospital-affiliated or freestanding facilities providing psychiatric care, with a total of 495 psychiatric beds for adults and 154 beds for children/adolescents. The state has 18 facilities offering chemical dependency services, with 324 beds for adults and 71 beds for children/adolescents. In addition, the state has four psychiatric residential treatment facilities, with a total of 158 beds, offering long-term care to emotionally disturbed children and adolescents who need restorative residential treatment services.

F. Local Health Departments

There are 82 local health departments organized in Mississippi, 14 full time clinics, 17 part-time clinics, nine Home Health Agencies, and nine Public Health Districts. All function under the direction of the Mississippi State Board of Health, whose members are appointed by the governor. The responsibility of the State Board of Health is to ensure that public health policies and procedures are carried out in each county. Local Health Department employees perform responsibilities related to sanitation, immunization, health promotion, disease surveillance, and disease outbreak in the county.

There are 3,023 authorized public health positions, of which 2,500 are filled. Since local health departments receive only a small percentage of their operating budgets from state and local governments, fees are charged for many of the provided services.

The mission of the Mississippi State Department of Health is to promote and protect the health of the citizens of Mississippi. The agency has established health promotion, disease prevention, and the control of communicable diseases as its major objectives. Communicable disease services include epidemiology, screening, surveillance, diagnosis, and treatment in areas such as tuberculosis, sexually transmitted diseases, and AIDs. Programs attempt to control disease transmission through effective intervention, treatment, and immunization where possible. In addition, the immunization program strives to eliminate morbidity and mortality from vaccine-preventable diseases.

The MSDH maintains programs to reduce the risk of particular health problems and to control or prevent such noncommunicable diseases as diabetes, cancer, hypertension, and cardiovascular disease. Other components of public health include services to:

1. Improve nutrition through providing supplemental foods and nutrition education to low income pregnant or breast-feeding women and to infants and children up to five years of age (accomplished through the WIC program);

2. Improve family planning through contraceptive services and counseling;

3. Improve maternal health through prenatal and postpartum care for maternity patients and access to enhanced delivery services for high risk pregnant women;

4. Contribute to the health of children and youth through the Early Periodic Screening, Diagnosis, and Treatment program; the First Steps Early Intervention System for Infants and Toddlers; the Children's Medical Program; school nurse services; and other services for infants, children, and adolescents;

5. Control or prevent problems that can endanger public health through protection of consumers against preventable hazards in food, milk, and water; maintenance and enforcement of regulatory standards regarding proper wastewater disposal; radiological safeguards; and consultation on public health pest management;

6. Support the detection, analysis, and treatment of public health problems;

7. Enhance the state's emergency medical services through development of a statewide trauma plan and licensing of ambulance services and emergency medical technicians;

8. Enforce established standards in the delivery of health care through

inspection and licensure of hospitals, nursing homes, and other health care facilities;

9. Maintain public records such as birth, deaths, utilization of health care services, and other statistical information regarding the health of Mississippians for the purpose of tracking public health trends and needs; and,

10. Support the planning and development of policies and standards for public health services.

G. Emergency Medical Services

Emergency medical services (EMS) are health care services delivered under emergency conditions that occur as a result of the patient's condition, natural disasters, or other situations. Emergency medical services are provided by public, private, or non-profit entities with the authority and the resources to effectively administer the services.

1. Present Status

The MSDH subdivided the state into six EMS tax-supported districts for the purpose of decentralizing the EMS program through EMS Authorities operating within each district. Within each district, a county has the option to participate with these authorities. Approximately 50 percent of the state's 82 counties presently participate in regional EMS programs. Counties who chose not to participate provide emergency services on an individual basis.

Three in-state and three out-of-state helicopter air ambulance services are licensed to operate in Mississippi. The in-state services are based in Tupelo, Jackson, and Hattiesburg.

2. Emergency Medical Trauma Plan

In 1991, the Legislature designated the MSDH Division of Emergency Medical Services as the lead agency to develop a trauma care plan for the state that addresses the triage, transportation, and treatment of major trauma victims. In 1997 the Legislature created a 17-member Trauma Task Force to assist the MSDH in continuing the development of Mississippi's Trauma Care Plan.

3. Statewide Trauma Care System

The Trauma Care Task Force formally presented its findings on December 15, 1997. The report was used as a guideline for the drafting and subsequent passage of House Bill 966, an act relating to a Statewide Trauma Care System.

The legislation gave authority to the Mississippi State Department of Health's Division of Emergency Medical Services for development of the state's Trauma

Care System. A permanent source of revenue to partially support the system was established via the Mississippi Trauma Task Fund. Additionally, revenue will be requested during the 1999 session of the Legislature for the balance of the projected $8 million system cost.

4. Emergency Medical Personnel and Training

EMT training involves EMT-Basic (EMT-B), EMT-Intermediate (EMT-I), and EMT-Paramedic (EMT-P). Mississippi requires all ambulance drivers to have EMS driver certification (EMS-D). To qualify for driver certification, an individual must complete an approved driver training program that involves driving tasks, vehicle dynamics, vehicle preventive maintenance, driver perception, night driving, and information on different driving maneuvers. This training offers both academic and clinical (practical hands on) experiences for the prospective ambulance driver. EMT-B training includes basic life support, airway, breathing, and circulation procedures. Automated External Defibrillation (AED) is an optional skill that local ambulance providers may include if they ensure state-approved protocols, local medical control, quality assurance activities, and appropriate training. The EMT-B also provides assessment and non-invasive therapies.

The EMT-I and EMT-P receive training in basic life support and advanced life support, also in accordance with federal Department of Transportation standards. Advanced life support involves basic life support plus definitive therapy. The emergency physician, the EMT-I, and the paramedic constitute the advanced life support team. This team assesses and aggressively treats life-threatening conditions using advanced airway maneuvers, invasive procedures, cardiac monitors, drugs, defibrillation, intravenous fluids, and other adjuncts.

Mississippi has 133 licensed ambulance providers, including four out-of-state providers — one in Alabama, two in Louisiana, and one in Tennessee. The Division of EMS reported 471 permitted vehicles in 1998 — 457 ground units and 14 fixed or rotary wing units. The Division has certified the following numbers of EMT personnel:

Emergency Medical Service Drivers	3,582
Emergency Medical Technician Basic	2,242
Emergency Medical Technician Intermediate	258
Emergency Medical Technician Paramedic	940

H. Availability of Adequate Health Manpower

Essential health service delivery requires an adequate supply and appropriate distribution of fully qualified physicians, nurses, and other health personnel. Mississippi has an adequate total of physicians to meet national standards; however, the physicians are maldistributed through the state. As of May 1998, 62 counties or portions of counties were designated as health professional shortage areas for primary medical care. Mississippi needs to further encourage the training of primary care physicians who will practice in designated underserved areas. Consideration should be given to using

community hospitals more extensively for residency training in family medicine.

Approximately 40 percent of Mississippi's dentists practice in the two major metropolitan areas: Jackson and the Gulf Coast. The state's goal is to improve the distribution of dentists so that no county has more than 5,000 persons per dentist and primary dental care is available within 30 minutes travel time of all areas.

The need for nurses is expected to undergo substantial change as managed care becomes more prevalent in the state. The Mississippi Nurses Association and 24 nursing organizations are working together through the Association's Nursing Organization Liaison Committee to address nursing manpower issues related to anticipated changes in the workplace. Through the efforts of this group, the Mississippi Legislature authorized an Office of Nursing Workforce Redevelopment to develop a statewide model for predicting nursing manpower needs and to initiate methods of transitioning nurses as needed from jobs in the acute care setting to jobs in the community.

The supply of allied health professionals has increased in recent years, with the work force distributed to virtually all health care settings. Firm conclusions about the supply and demand for allied health personnel are difficult to draw, because very little data is available for the study of these groups of health professionals. However, officials believe that changes in the health care delivery system, the aging of the population, and advances in health service techniques and technology will continue to increase the demand for qualified technologists and technicians.

I. Rural Health Personnel

Mississippi continues to experience chronic shortages of physicians in rural areas. The Office of Primary Care Liaison, Office of Rural Health, and the University of Mississippi Medical Center assist the community in its efforts to alleviate shortages through recruitment of physicians. Additional efforts to address physician shortages will be made through a Robert Wood Johnson initiative called the “Southern Rural Access Program”, scheduled to begin in 1999.

1. Health Professional Shortage Areas

The Federal Division of Shortages Designation (DSD), Department of Health and Human Services, upon the advice and recommendation of the Mississippi State Department of Health, designates certain areas as Health Professional Shortage Areas (HPSAs). The designations are usually geographic areas consisting of a county or a sub-county area and are based on the ratio of certain primary care health professionals to the population. Currently, there are 59 HPSAs, including 48 whole counties, five partial counties, four population group designations, and two facility designations. (See Map I .)

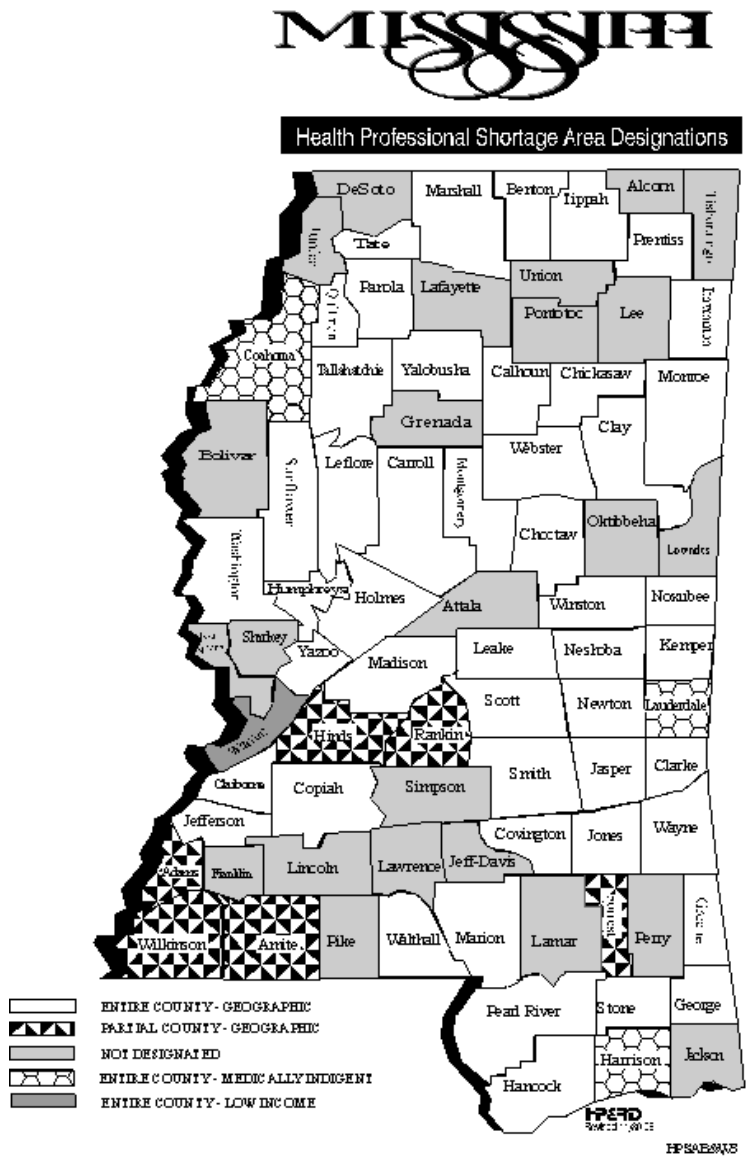
2. Medically Underserved Areas

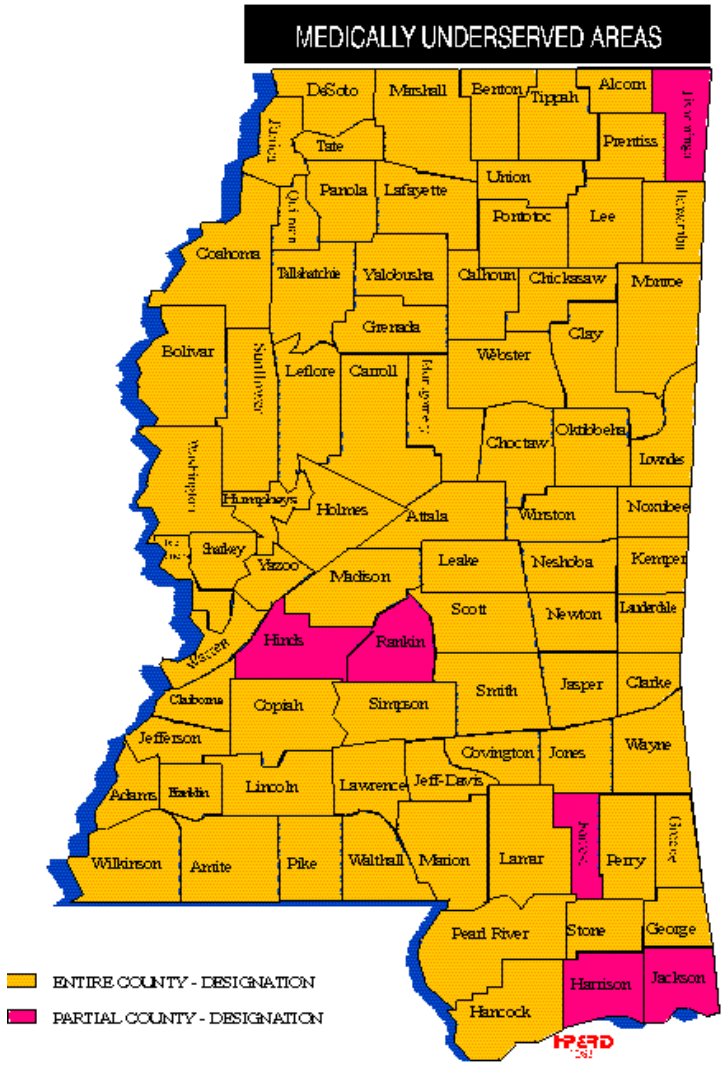
Every county in Mississippi is federally designated, whole or in part, as a Medically Underserved Area (MUA). Of the 82 total counties, 76 are wholly designated as MUAs and six as partial MUAs. (See Map II.)

2. The National Health Service Corps (NHSC)

The Nation Health Service Corps is an active federal program that offers loan repayment and scholarship incentives in exchange for a service obligation to a facility that meets Federal guidelines and is located in a Health Professional Shortage Area. The guidelines were revised in 1997 to make the utilization of this program more accessible for facilities throughout Mississippi.

There are 31 NHSC providers currently practicing in Mississippi: 12 are primary care physicians, 11 are dentists, and eight are nurse practitioners.


Health Professional Shortage Area Designations
DeSoto
Marshall
Benton
Tippah
Alcorn
Tishomingo
Tate
Prentiss
Union
Panola
Lafayette
Pontotoc
Lee
Itawamba
Quitman
Coahoma
Tallahatchie
Yalobusha
Calhoun
Chickasaw
Monroe
Grenada
Clay
Bolivar
Sunflower
Leflore
Carroll
Montgomery
Webster
Choctaw
Oktibbeha
Lowndes
Washington
Humphreys
Holmes
Attala
Winston
Noxubee
Sharkey
Yazoo
Madison
Leake
Neshoba
Kemper
Issaquena
Scott
Newton
Lauderdale
Warren
Hinds
Rankin
Smith
Jasper
Clarke
Claiborne
Copiah
Simpson
Jefferson
Covington
Jones
Wayne
Adams
Franklin
Lincoln
Lawrence
Jeff-Davis
Jefferson Davis
Wilkinson
Amite
Pike
Walthall
Marion
Lamar
Forrest
Perry
Greene
Pearl River
Stone
George
Harrison
Jackson
Hancock
ENTIRE COUNTY - GEOGRAPHIC
PARTIAL COUNTY - GEOGRAPHIC
NOT DESIGNATED
ENTIRE COUNTY - MEDICALLY INDIGENT
ENTIRE COUNTY - LOW INCOME
HPSA8/98


MEDICALLY UNDERSERVED AREAS
DeSoto
Marshall
Benton
Tippah
Alcorn
Tishomingo
Tate
Prentiss
Union
Panola
Lafayette
Pontotoc
Lee
Itawamba
Coahoma
Quitman
Tallahatchie
Yalobusha
Calhoun
Chickasaw
Monroe
Grenada
Clay
Bolivar
Sunflower
Leflore
Carroll
Webster
Choctaw
Oktibbeha
Lowndes
Washington
Humphreys
Holmes
Attala
Winston
Noxubee
Sharkey
Yazoo
Madison
Leake
Neshoba
Kemper
Scott
Newton
Lauderdale
Warren
Hinds
Rankin
Smith
Jasper
Clarke
Claiborne
Copiah
Simpson
Jefferson
Covington
Jones
Wayne
Adams
Franklin
Lincoln
Lawrence
Jeff-Davis
Wilkinson
Amite
Pike
Walthall
Marion
Lamar
Perry
George
Pearl River
Stone
Harrison
Jackson
Hancock
ENTIRE COUNTY - DESIGNATION
PARTIAL COUNTY - DESIGNATION

Of these practitioners, two are NHSC federal assignees, four are NHSC Scholars, and 25 are NHSC Loan Repayees.

Currently there are 27 sites on the vacancy list.

III. MISSISSIPPI RURAL HOSPITAL FLEXIBILITY PROGRAM

A. Medicare Rural Hospital Flexibility Program

As part of the Balanced Budget Act of 1997, Congress authorized the Medicare Rural Hospital Flexibility Program (MRHFP). The Health Care Financing Administration (HCFA) published regulations implementing the MRHFP in the August 27, 1997 issue of the Federal Register. The Program became effective October 1, 1997. A final rule regarding the Program was published in the May 12, 1998 Federal Register. The MRHFP creates the Critical Access Hospital (CAH), an acute care facility that provides outpatient, emergency, and limited inpatient services, and is recognized as a new provider type eligible for cost based Medicare reimbursement.

Rural public or nonprofit hospitals are eligible to convert to CAH status. The Program defines a rural hospital as one located outside a Metropolitan Statistical Area. The facility may operate up to 15 acute care beds and provide services to inpatients for up to 96 hours. A CAH that participates in the swing bed program may operate up to 25 beds, provided that no more than 15 of the beds are used for acute care at any one time. At least one or more CAHs and full service hospitals may be organized into rural health care networks which have agreements for patient referral and transfer, the development and use of communication systems, the provision of emergency and non-emergency transfer, and a mechanism for staff credentialing and quality assurance. HCFA will reimburse CAHs on a reasonable cost basis for inpatient and outpatient services provided to Medicare beneficiaries.

B. The Mississippi Rural Hospital Flexibility Act of 1998

The 1998 session of the Mississippi Legislature authorized the Mississippi State Department of Health (MSDH) to develop a state rural health care plan, to adopt rules and regulations for the designation of CAHs and rural health networks, and to provide for insurance reimbursement for services provided by CAHs if such services would be covered if provided in a full service hospital. The legislation states that "it is the policy of the State of Mississippi to provide improved access to hospital and other services for rural residents of the State of Mississippi and to promote regionalization of rural health services in Mississippi." See Appendix A for a copy of the legislation.

The state enabling legislation stipulates that the state rural health care plan will be developed by the MSDH in consultation with the Mississippi Hospital Association, the executive director of the Mississippi Board of Supervisors, and rural hospitals located in the state. An ad hoc committee with representation from

the above groups was formed to develop the plan. See Appendix B for a list of committee members.

C. Critical Access Hospital Designation

To satisfy state requirements for designation as a CAH, a hospital must first agree to meet all federal requirements for designation. After all state requirements have been met, the MSDH Division of Licensure and Certification will survey for conversion to CAH status.

D. Federal Criteria/Assurance

A hospital must meet the following federal statutory requirements for designation as a Critical Access Hospital:

1. Be a public or nonprofit hospital located in a rural area (non-Metropolitan Statistical Area) that is

   a. located more than a 35 mile drive, or 15 miles in mountainous terrain or areas with only secondary roads, as indicated in the current Mississippi Official Highway Map, from another hospital or CAH,
   OR
   b. is certified by the state as being a necessary provider of health care services to residents in the area;

2. Makes available 24-hour emergency care services that a state determines are necessary for ensuring access to emergency care in each area served by a CAH;

3. Operates not more than 15 acute inpatient beds (or 25 beds if the facility participates in the swing bed program provided that no more than 15 of the beds are used for acute care at any one time);

4. Limits inpatient stays to no more than 96 hours unless transfer to a hospital is precluded due to inclement weather or other emergency conditions, except that a peer review organization or equivalent entity may also, on request, waive the 96 hour restriction on a case by case basis;

5. Meets CAH staffing requirements;

6. Is a member of a rural health network; and,

7. Has an agreement with at least one hospital that is a member of the network for

a. patient referral and transfer;

b. the development and use of communications systems;

c. the provision of emergency and non-emergency transportation; and,

a. credentialing and quality assurance.

E. State Criteria for Determining a Necessary Provider of Health Care Services

A hospital that does not meet the federal mileage requirements to be certified as a Critical Access Hospital and is otherwise eligible for designation will be certified by the state as a necessary provider of health care services if it meets two (2) or more of the following criteria:

Criteria 1. The hospital is located in a county that is federally designated as a Health Professional Shortage Area (HPSA) for medical care.

Criteria 2. The hospital is located in a county that is federally designated as a Medically Underserved Area (MUA).

Criteria 3. The hospital is located in a county where the percentage of families with incomes less than 100 percent of the federal poverty level is higher than the state average for families with incomes less than 100 percent of poverty.

Criteria 4. The hospital is in a county with an unemployment rate that exceeds the state's average unemployment rate.

Criteria 5. The hospital is located in a county with a percentage of population age 65 and older that exceeds the state's average.

Criteria 6. The number of Medicare admissions to the hospital exceeds 50 percent of the facility's total number of admissions as reported in the most recent Hospital Annual Report for the facility.

Any hospital not meeting two (2) of the above criteria may appeal the decision of the MSDH Division of Health Planning and Resource Development. Appeals will only be considered that provide sound evidence that future access to health care for the citizens in the facility's primary service area, as defined by the most recent patient origin study, will be jeopardized if it is not declared a necessary provider of health care services.

F. State Designation Process

The MSDH will establish a Critical Access Hospital Certification Review Committee to include representatives of the MSDH Division of Health Planning and Resource Development, the Division of Licensure and Certification, the Division of Emergency Medical Services, and two (2) hospital representatives appointed by the Mississippi Hospital Association. The State Health Officer may appoint representatives of additional groups to the committee. The committee will:

1. Annually review the Mississippi Rural Hospital Flexibility Plan and recommend to the State Health Officer any necessary changes;

2. Update a listing of prospective hospital participants based on census data, length of stay data, and patient mix which approximates federal and state certification criteria;

3. Design and annually review information required from hospitals interested in designation as CAHs; and,

4. Review applications for CAH designation and recommend approval or disapproval to the State Health Officer.

G. Critical Access Hospital Designation Application

The Critical Access Hospital Designation Application will include the following information:

1. A community needs assessment which includes an inventory of local health services and providers;

2. Evidence of information activities to inform county and community residents, public officials, and health care providers of the proposed conversion of the hospital to CAH designation;

3. A financial feasibility study which will include

   a. audited financial statements and notes for the three most recently completed years;

   b. adult and pediatric admissions, adult and pediatric patient days, deliveries, and inpatient surgeries;

   c. outpatient and emergency room utilization data;

   d. an inventory of medical staff by name, age, and medical specialty;

e. a three year CAH cost and revenue projection;

1.F. a signed network agreement with a full service hospital detailing the facility relationships, including

6.A. patient referral and transfer;

ii. communications systems;

iii. provision of emergency and non-emergency transportation;

iv. arrangements for credentialing and quality assurance; and,

v. other information and data which the Review Committee may determine is needed to make an appropriate recommendation.

H. List of Potential Hospitals Eligible for Conversion to Critical Access Hospitals

See Appendix C.

Appendix A

MISSISSIPPI LEGISLATURE 1998 Regular Session

To: Public Health and Welfare; Appropriations By: Representative Moody

House Bill 1025 (As Sent to Governor)

AN ACT TO CODIFY SECTIONS 41-9-201 THROUGH 41-9-217, MISSISSIPPI CODE OF 1972, TO BE ENTITLED THE MISSISSIPPI RURAL HOSPITAL FLEXIBILITY ACT OF 1998; TO AUTHORIZE THE STATE DEPARTMENT OF HEALTH TO DEVELOP A STATE RURAL HEALTH CARE PLAN, IN ACCORDANCE WITH FEDERAL LAW, WHICH CREATES RURAL HEALTH NETWORKS IN THE STATE AND DESIGNATES RURAL NONPROFIT OR PUBLIC HOSPITALS OR FACILITIES AS CRITICAL ACCESS HOSPITALS; TO PROVIDE CERTAIN CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITALS; TO AUTHORIZE THE STATE DEPARTMENT OF HEALTH TO PROMULGATE RULES AND REGULATIONS FOR THE ESTABLISHMENT OF RURAL HEALTH NETWORKS AND CRITICAL ACCESS HOSPITALS; TO PROVIDE INSURANCE AND OTHER COVERAGE TO PROVIDE BENEFITS FOR SERVICES PERFORMED BY CRITICAL ACCESS HOSPITALS; AND FOR RELATED PURPOSES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MISSISSIPPI:

SECTION 1. The following provision shall be codified as Section 41-9-201, Mississippi Code of 1972:

41-9-201. Short Title.

This article is entitled and may be cited as the Mississippi Rural Hospital Flexibility Act of 1998.

SECTION 2. The following provision shall be codified as Section 41-9-203, Mississippi Code of 1972:
41-9-203. State Policy. It is the policy of the State of Mississippi to provide improved access to hospital and other health services for rural residents
of the State of Mississippi and to promote regionalization of rural health services in Mississippi.

SECTION 3. The following provision shall be codified as Section 41-9-205, Mississippi Code of 1972:

41-9-205. Definitions.

When used in this article, the following definitions shall apply, unless the context indicates otherwise:

(a) "Act" means the Mississippi Rural Hospital Flexibility Act of 1998.

(b) "Critical access hospital" means a hospital which has been designated as a critical access hospital by the department in accordance with the Medicare Rural Hospital Flexibility Program, as provided for

in Section 4201 of the Balanced Budget Act of 1997, Public Law 105-33, and which has entered into an agreement with at least one (1) full-service hospital to form a rural health network. The agreement or agreements must include provisions regarding patient referral and transfer, communications and patient transportation. A critical access hospital in a rural health network must also have an agreement for credentialing and quality assurance with at least one (1) hospital that is a member of the rural health network, or with a peer review organization or equivalent entity, or with another appropriate and qualified entity identified in the rural health care plan for the State of Mississippi.

(c) "Department" means the Department of Health for the State of Mississippi.

(d) "Rural health network" means an organization consisting of at least one (1) critical access hospital and at least one (1)full-service hospital, the members of which have entered into certain agreements regarding patient referral and transfer, the development and use of communications systems and the provision of emergency and nonemergency transportation.

(e) "State rural health care plan" means Mississippi's rural health care plan that (i) provides for the creation of one or more rural health networks, consisting of at least one (1) critical access hospital and at least one (1) full-service hospital, (ii) promotes regionalization of rural health services in Mississippi, and (iii) improves access to hospitals and other health services for rural residents of Mississippi.

SECTION 4. The following provision shall be codified as Section 41-9-207, Mississippi Code of 1972:

41-9-207. State Rural Health Care Plan.

(1) The department is hereby authorized, in accordance with the Medicare Rural Hospital Flexibility Program, as authorized by Section 4201 of the Balanced Budget Act of 1997, Public Law 105-33, to develop for the State of Mississippi a state rural health care plan that (a) provides for the creation of one or more rural health networks in Mississippi; (b) promotes regionalization of rural health services in Mississippi; and (c) improves access to hospitals and other health services for rural residents of Mississippi.

(2) The state rural health care plan shall be developed in consultation with the Mississippi Hospital Association, the Executive Director of the Mississippi Board of Supervisors, or his designee, and rural hospitals located in Mississippi.

(3) In developing the state rural health care plan, the department shall designate rural nonprofit or public hospitals or facilities located in Mississippi as critical access hospitals, which critical access hospitals must meet the criteria for such designation as set out in Section 4201 of the Balanced Budget Act of 1997.

SECTION 5. The following provision shall be codified as Section 41-9-209, Mississippi Code of 1972:

41-9-209. Designation as a Critical Access Hospital.

Any hospital is authorized to seek designation as a critical access hospital. There shall be no requirement or limitation regarding the distance that a critical access hospital must be located from another hospital. The bed-size limit for a critical access hospital is fifteen (15) operational beds, and the maximum length of stay for a patient in a critical access hospital is ninety-six (96) hours, unless a longer period is required because of inclement weather or other emergency conditions, or a peer

review organization or other equivalent entity, or request, waives the ninety-six-hour restriction. An exception to the bed-size requirement is made for swing-bed facilities, which may have up to

twenty-five (25) inpatient beds, provided that not more than fifteen (15) beds are used at any one (1) time for acute care. A critical access hospital (a) must make available twenty-four-hour emergency care services, as described in the state rural health care plan, for ensuring access to emergency care services in the rural area served by the critical access hospital, and (b) must be a member of a rural health network. Any hospital that has a distinct-part skilled nursing facility, certified under Title XVIII of the federal Social Security Act, at the time it applies for designation as critical access hospital, is not required to count the beds in the distinct-part skilled nursing facility for purposes of the allowed fifteen (15) acute care inpatient beds. Notwithstanding anything to the contrary in Section 41-7-171 et seq., (1) the distinct-part skilled nursing facility beds of such hospital applying for designation as a critical access hospital shall be deemed licensed under state law as distinct-part skilled nursing facility beds, which licensure designation will remain in effect as long as (i) such hospital is applying for or is designated and functions as a critical access hospital and (ii) such beds are certified as distinct-part skilled nursing facility beds under Title XVIII of the federal Social Security Act and (2) the distinct-part geriatric psychiatric unit beds of a hospital applying for designation as a critical access hospital shall be deemed licensed under state law as psychiatric beds, which licensure designation will remain in effect as long as (i) such hospital is applying for or is designated and functions as a critical access hospital and (ii) such beds are certified as distinct-part geriatric psychiatric unit beds under Title XVIII of the federal Social Security Act. Any distinct-part skilled nursing facility bed or distinct-part geriatric psychiatric unit bed receiving licensure designation as set forth in this section will not be counted against the bed need set forth in the State Health Plan, as defined in Section 41-7-173.

SECTION 6. The following provision shall be codified as Section 41-9-211,

Mississippi Code of 1972:

41-9-211. Formation of a Rural Health Network Not Subject to Antitrust Laws.

In forming an integrated network and in contracting for services, members of a rural health network and officers, agents, representatives, employees and directors of any member thereof shall be considered to be acting pursuant to clearly expressed state policy as established in this act under the supervision of the State of Mississippi and shall not be subject to state or federal antitrust laws while so acting.

SECTION 7. The following provision shall be codified as Section 41-9-213, Mississippi Code of 1972:

41-9-213. Rules and Regulations.

The department shall adopt, in accordance with Section 25-43-1 et seq., Mississippi Code of 1972, rules and regulations for the establishment and operation of rural health networks, including the designation of critical access hospitals of rural areas and minimum standards, as necessary, for such critical access hospitals.

SECTION 8. The following provision shall be codified as Section 41-9-215, Mississippi Code of 1972:

41-9-215. Insurance and Other Coverage to Provide Benefits for Services Performed by critical access hospitals.

Each individual and group policy of accident and sickness insurance, each contract issued by health maintenance organizations, and all coverage maintained by an entity authorized under any article of Chapter 41, Title 83 of the Mississippi Code of 1972, shall provide benefits for services when performed by a critical access hospital if such services would be covered under such policies or contracts if performed by a full-service hospital.

SECTION 9. The following provision shall be codified as Section 41-9-217, Mississippi Code of 1972:

41-9-217. Additional Personnel.

The department is hereby authorized to hire additional personnel to implement this act pursuant to specific appropriations to
the department for such purposes.

SECTION 10. This act shall take effect and be in force from and after its passage.

APPENDIX B

CRITICAL ACCESS HOSPITAL AD HOC COMMITTEE

Chairman:	Bill Henderson, Greenwood Leflore Hospital
Members:	Brock Slabach, Field Memorial Hospital
	Charles Knight, Gilmore Memorial Hospital
	Arthur M.. Nester, Noxubee General Hospital
	Clint Gee, Kilmichael Hospital
	Winfred Wilkerson, Sharkey-Issaquena Community Hospital
	Michael R. Edwards, Scott Regional Hospital
	Debra L. Griffin, Humphreys County Memorial Hospital
	Arthur Kelly, Oktibbeha County Hospital
	Kenneth Posey, Jasper General Hospital
	Joel Yelverton, Mississippi Association of Supervisors
	Harold B. Armstrong, Mississippi State Department of Health
	David Lightwine, Mississippi State Department of Health
	Mary M. Patterson, Mississippi Hospital Association

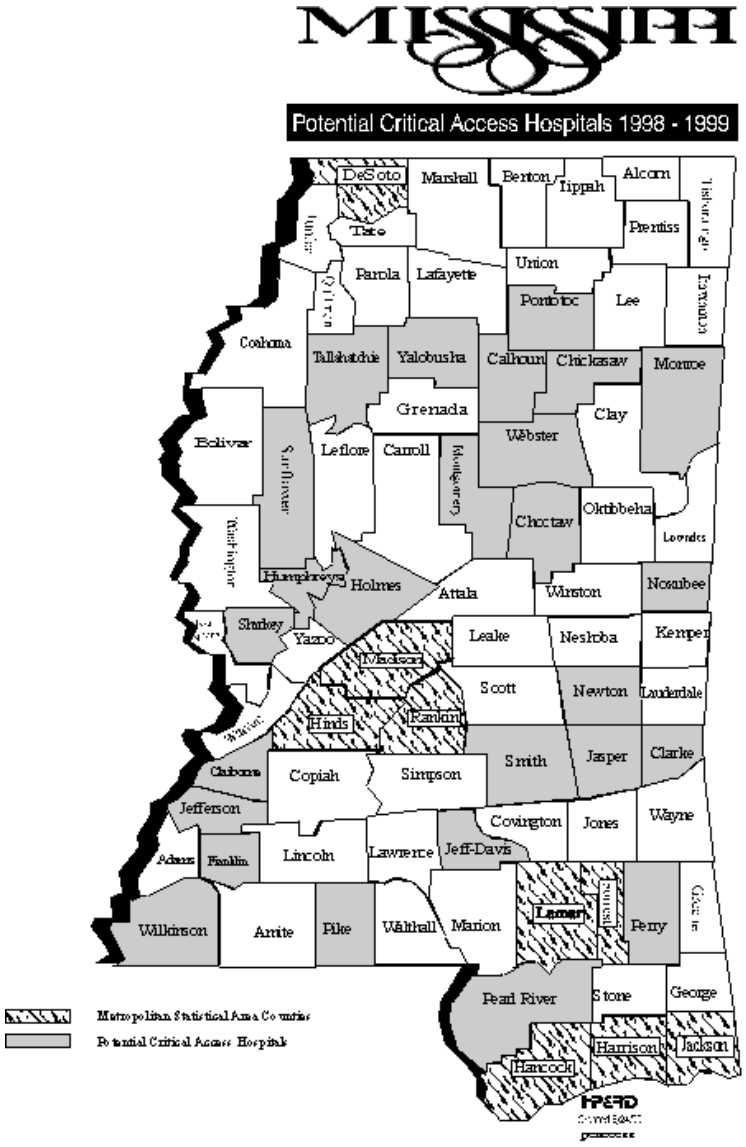
APPENDIX C

LIST OF POTENTIAL CRITICAL ACCESS HOSPITALS
1998-1999

Medicare and Medicaid Admissions and Average Length of Stay
and Average Daily Census for 1996

Hospital	Medicare Admissions	Medicaid Admissions	ALOS	ADC
Total	11,469	4,249		
Aberdeen-Monroe County Hospital	439	53	4.65	7.89
Beacham Memorial Hospital	767	74	5.71	15.19
Choctaw County Hospital	165	77	4.14	3.31
Claiborne County Hospital	369	239	6.95	14.99
Franklin County Memorial Hospital	389	179	7.62	12.34
Hillcrest Hospital	545	70	3.48	6.65
Holly Springs Memorial Hospital	595	110	6.20	15.66
Humphreys County Memorial Hospital	481	222	5.73	14.85
Jasper General Hospital	195	51	5.37	3.17
Jefferson County Hospital	281	316	3.92	7.61
Jefferson Davis County Hospital	336	135	4.07	6.63
Kilmichael Hospital	421	60	5.46	8.30
Newton Regional Hospital	638	324	3.80	13.63
North Miss. Medical Center - Pontotoc	505	40	7.44	12.98
North Sunflower County Hospital	592	326	4.27	13.34
Noxubee General Hospital	474	145	5.21	10.60
Okolona Community Hospital	114	27	2.77	1.58
Pearl River County Hospital	353	245	3.29	7.72
Perry County General Hospital	220	103	5.18	5.58
Quitman County Hospital	524	326	4.65	11.19
Senatobia Community Hospital	550	371	4.64	15.43
Sharkey-Issaquena Community Hospital	192	108	4.87	5.71
Smith County General Hospital	304	209	5.15	7.48
Tallahatchie General Hospital & ECF	317	81	4.45	5.19
University Hospital Durant	459	107	5.96	15.09
Webster Health Services	842	166	4.19	15.84
Yalobusha General Hospital	402	85	4.37	5.51

Note: Appendix C revised 6/30/99 as per David Lightwine


MISSISSIPPI
Potential Critical Access Hospitals 1998 - 1999
DeSoto
Marshall
Benton
Tippah
Alcorn
Tishomingo
Tate
Prentiss
Tunica
Panola
Lafayette
Union
Quitman
Pontotoc
Lee
Itawamba
Coahoma
Tallahatchie
Yalobusha
Calhoun
Chickasaw
Monroe
Grenada
Clay
Bolivar
Sunflower
Leflore
Carroll
Webster
Montgomery
Choctaw
Oktibbeha
Lowndes
Washington
Humphreys
Holmes
Attala
Winston
Noxubee
Issaquena
Sharkey
Yazoo
Leake
Neshoba
Kemper
Madison
Scott
Newton
Lauderdale
Warren
Hinds
Rankin
Smith
Jasper
Clarke
Claiborne
Copiah
Simpson
Jefferson
Covington
Jones
Wayne
Adams
Franklin
Lincoln
Lawrence
Jeff-Davis
Lamar
Forrest
Perry
Greene
Wilkinson
Amite
Pike
Walthall
Marion
Pearl River
Stone
George
Harrison
Jackson
Hancock
Metropolitan Statistical Area Counties
Potential Critical Access Hospitals